DOCUMENT RESUME

ED 264 490 CG 018 718

AUTHOR Hwalek, Melanie A.; Sengstock, Mary C.
TITLE A Screening Instrument for Identifying Elderly at Risk of Abuse and Neglect.
SPONS AGENCY Department of Health and Human Services, Washington, D.C.
PUB DATE Nov 85
GRANT 90-AR-0040/2
NOTE 18p.; Paper presented at the Annual Scientific Meeting of the Gerontological Society (38th, New Orleans, LA, November 22-26, 1985).
PUB TYPE Speeches/Conference Papers (150) -- Tests/Evaluation Instruments (160) -- Reports - Research/Technical (143)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Elder Abuse; Financial Problems; *High Risk Persons; Identification; Marital Instability; *Older Adults; Psychological Characteristics; Risk; *Screening Tests; Stress Variables; *Test Validity
IDENTIFIERS Caregivers; Hwalek Sengstock Elder Abuse Screening Protocol

ABSTRACT

Recently more attention has been focused on elder abuse, with laws enacted requiring reporting of this crime. Since service providers often do not recognize elder abuse, a validated screening tool for elder abuse is needed. A screening tool called the Hwalek-Sengstock Elder Abuse Screening Protocol has been developed and is currently being validated. The screening tool contains 16 indicators which include the following: (1) the elderly person's feelings of fear, unwantedness, or depression; (2) the caretaker's alcohol abuse, financial dependence on the elderly person, lying, stressed condition, or misunderstanding of the elderly person's condition; (3) the elderly person has been threatened, hurt or his personal needs not met; (4) marital stress in the family; and (5) financial stress in the family. Content validity, criterion related validity, and construct validity are examined and a reliability study is planned. This tool has advantages over other tools because it examines psychological and behavioral indicators rather than just demographic indicators. A need for further validation by the research community is noted. (The Hwalek-Sengstock Elder Abuse Screening Protocol is included.) (ABL)

**********
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
**********

ED264490

# A SCREENING INSTRUMENT FOR IDENTIFYING ELDERLY AT RISK OF ABUSE AND NEGLECT

Melanie A. Hwalek, Ph.D.
Research Associate
Institute of Gerontology

and

Mary C. Sengstock, Ph.D.
Chairperson & Professor
Department of Sociology

Wayne State University
Detroit, Michigan 48202
(313) 577-2297

CG 018718

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Melanie Hwalek

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Paper presented at the 38th Annual Scientific Meeting of the Gerontological Society of America, New Orleans, November, 1985.

This paper was supported, in part, by a grant from the Illinois Department on Aging and Grant No. 90-AR-0040/2 from the Department of Health and Human Services, Administration on Aging. The views and opinions expressed herein are those of the authors and not necessarily those of these funding sources.

The authors would like to acknowledge the assistance of Ms. Janet S. Otwell, Director and Ms. Carolyn Cochran, Elder Abuse Program Manager at the Illinois Department on Aging for their support and cooperation in the collection of data used in this paper. The authors would also like to acknowledge Ms. Helen Lownie for her bibliographic assistance in the prepartaion of this manuscript.

# A SCREENING INSTRUMENT FOR IDENTIFYING ELDERLY AT RISK OF ABUSE AND NEGLECT

MELANIE A. HWALEK, PH.D.
AND
MARY C. SENGSTOCK, PH.D.

WAYNE STATE UNIVERSITY
DETROIT, MICHIGAN 48202

Identifying elderly victims of abuse and/or neglect is an important prerequisite to preventing and alleviating the problem. In this paper, the present status of the development of the Hwalek-Sengstock Elder Abuse Screening Protocol is discussed.

This paper describes the risk assessment tool and explains how the items were selected. The content validity of the protocol is discussed by relating individual items to past research and professional literature on the topic. Data from four elder abuse demonstration projects funded by the Illinois Department on Aging is used to illustrate the validity of those items not discussed in the current elder abuse literature.

While the reader is cautioned not to use the instrument until further validation studies are completed, the potential advantages of this index over similar risk assessment instruments is discussed. A copy of the latest version of the Hwalek-Sengstock Elder Abuse Screening Protocol is included with the paper.

## Introduction

In recent years, agencies working with the elderly have begun to develop techniques for the identification of aged persons who may be victims of abuse by their families or other caretakers. To a considerable extent, the effort to develop such techniques reflects a growing concern for the problem of elder abuse and maltreatment. The problem has been the focus of a number of studies analyzing the nature of elder abuse and maltreatment as well as the characteristics of elders subject to abuse (Block and Sinnott, 1979; Douglass, Hickey and Noel, 1980; Sengstock and Liang, 1982; Lau and Kosberg, 1979). Even more noteworthy has been the enactment of laws requiring elder abuse to be reported to authorities in much the same manner that child abuse is reported. These laws specify which persons are required to report adult abuse, to whom they must report it, when an investigation must begin, the sanction which will apply to persons who fail in this duty, the conditions which govern state intervention to stop the abuse, and so on (Salend et al., 1984).

Authorities have noted that victims of domestic abuse are often overlooked by service providers (Lau and Kosberg, 1979; Douglass et al, 1980). Consequently, many victims of family abuse must endure their plight alone and in silence, since their difficulties are often known only to themselves and to those responsible for their victimization. The availability of an accurate screening instrument can suggest to authorities which cases warrant further investigation for potential or existing abuse or neglect. It can also provide a cost-effective mechanism for examining the epidemiology of abuse and neglect of the aged among community elderly who have little or no contact with social service agencies.

Screening instruments are not new to social research. Such instruments are being used to detect alcoholism (Michigan Alcoholism Screening Test) and domestic violence in other age groups (Wife Abuse Inventory of Lewis (1985)). To our knowledge, however, no validated instrument has been developed to screen for the possibility of elder abuse or neglect. The purpose of this study is to move the gerontological research and service community closer to establishing such a screening tool.

Over the past two years, the authors have been involved in the development and validation of the Hwalek-Sengstock Elder Abuse Screening Protocol. The research on this instrument has aimed to address psychometric issues important to the development of any psychological test: validity, reliability, and the ease of use by service providers. In this paper, the research done to date in validating the Hwalek-Sengstock Elder Abuse Screening Protocol will be detailed, and future directions of research on this tool will be suggested.

Before investigating validation issues, a brief description of the screening protocol is in order.

## Description of the Screening Protocol

The Hwalek-Sengstock Elder Abuse Screening Protocol contains 16 different indicators that have been shown to discriminate adequately between victims of abuse and control cases in a previous investigation (Hwalek and Sengstock, 1984). The following items are included in this instrument:

(1) The elderly's personal needs are not being met.

(2) Someone has taken money or property from the elderly.

(3) Someone has threatened to hurt the elderly.

(4) The elderly person is afraid of the caretaker or others.

(5) Financial stress in the family.

(6) The elderly is showing signs of depression.

(7) The elderly does not share in decision making.

(8) Marital stress in the family.

(9) The caretaker shows inappropriate awareness of the elder's condition.

(10) The elder is unwanted.

(11) There is no illness related cause behind the elder's symptoms.

(12) The caretaker or family member is misusing alcohol.

(13) The elder is a source of stress for the caretaker.

(14) The caretaker is financially dependent upon the elderly.

(15) Somebody tried to get the elderly to act against his/her own best interest.

(16) The caretaker is a persistent liar.

The screening protocol, listed in Table One, is designed to be read directly to the elderly client. It has gone through several revisions since the risk factors were determined. As can be seen by reading the instrument, questions were written that reflect each of the 16 indicators. To reduce response set of the elderly clients, four questions were worded in the opposite direction from the other twelve. The wording of the questions appear to be understandable to the elderly, as indicated by pretesting of the instrument at four elder abuse demonstration projects funded by the Illinois Department on Aging.

It should be noted that major assumptions were made in writing questions from the 16 indicators located in the Hwalek & Sengstock (1984) study. Clearly, each indicator could be represented by

several different questions. An earlier design of the instrument used 4 to 5 questions for each indicator. Testing of this instrument indicated that this design was too cumbersome for both the service providers and the elderly. Therefore, the best question from each set was selected to be included on the protocol. The decision was made to write direct questions instead of listing the indicators and asking for service providers perceptions in order to standardize the data collection process.

The instrument first gives a short introduction to the elderly client about why the questions will be asked, followed by questions which are to be read to the elderly by the service provider exactly as they are written. This design eliminates subjective interpretations about the existence of each indicator.

Thus, while the questions on the screening protocol may not thoroughly tap each indicator, their validity for assessing risk is best determined by the outcome of objective criterion-related data analyses, rather than by their face validity.

Now we will turn to the validity evidence obtained to date on this risk protocol.

## Validity

A valid test is one which measures the concept it was intended to measure, but does not measure other related concepts. Three types of validity should be investigated when developing any psychometric index. Each of these types of validity are being addressed in the development of the Hwalek-Sengstock Elder Abuse Screening Protocol.

## Content Validity

Content validity means that the content of the items used to screen for abuse pertain to elder abuse, and that the set of items comprising the scale are a representation of factors related to the abuse and neglect of the elderly. There is no generally accepted measure of content validity. To a large extent, it is a judgment of the researcher (Carmine & Zeller, 1979). Clear conceptualization of the risk of elder abuse is essential to the determination of content validity.

## Content Validity of the Screening Protocol

Many of the items on the risk protocol have been supported by past and present research on elder abuse. The risk indicators developed in the Hwalek-Sengstock protocol consist largely of items found in previous research to be related to those characteristics of the elderly and of their caretakers which lead to potential abuse. Although these indicators of risk have not been completely validated, a review of current literature and our own research indicates that the 16 items represent factors often found to be predictive of abuse. In the section which follows, we will discuss factors related to the content validity of the three categories of risk indicators.

1. Anyone taken any money or property?

In most studies, this characteristic represents the category of material or financial abuse discussed by Lau and Kosberg (1979), Wolf et al.,(1982) and Hwalek and Sengstock (1985). An elderly person who is impaired may rely on the caretaker to ensure that financial needs are met. This may include transferring funds to the caretaker's account so that checks may be deposited or cashed, bills may be paid, and so on. However, as mentioned by Lau and Kosberg (1979), sometimes the person in charge of the elderly's money does not appropriate funds in a way that meets the specific needs of the elder. In fact, often the funds may be used to purchase things for the caregiver's family while the elder's needs remain unmet (Lau and Kosberg, 1979).

2. Caretaker dependent on elder for financial support.

There is little information in the literature that touches upon this characteristic of potential abuse. Research conducted by Wolf et al. (1982) found that two-thirds of the cases examined reported that the abuser was dependent on the abused elder for financial support. Block and Sinnott (1979) present two case studies in which elderly women contributed their only income to their children with whom they were living. In one of the cases, the son quit his job, while the elderly mother babysat to provide additional income to the household (Block and Sinnott, 1979).

While the studies supporting this indicator are rare, they do provide some support that financial dependence of the caretaker may be found in future research to predict abuse of the elderly.

3. Financial stress in the family.

According to Wolf et al. (1982), and also Block & Sinnott (1979), the elderly are more likely to become a victim of financial maltreatment if they are perceived by their caretaker as being a major source of stress and in need of constant care.

4. Elder does not share in decisions.

Cases of verbal and emotional abuse often involved the removal of the elder's independence. According to Hickey and Douglass, "older adults were seen as verbally/emotionally abused when removed by family members as active participants from decision making processes concerning their own lives..." (Douglass and Hickey, 1981). Thus, it is reasonable to expect that this factor should predict risk of abuse.

5. Marital Discord in Familial Situation.

There is some evidence to suggest that caring for a dependent elderly parent may cause marital discord between the child and his/her spouse. Davidson (1979) noted that in some situations the job of caring for an aged adult may be the sole responsibility of a single adult member within a family. This problem may be

particularly difficult for a married, middle aged female caretaker who is torn between the responsibility for her family and for her parent (Davidson, 1979). Conversely, while not yet supported by research, previously existing marital stress may promote family violence, which could be displaced onto the elder.

6. Caretaker has an inappropriate awareness of the elder's condition.

An elderly person living with a young caretaker may be at risk of abuse in many situations. One possible explanation of why the caretaker takes his frustrations out on the elder is that they do not know how to deal with the emotional as well as physical needs of the elderly. According to Chen et al. (1981) "The major factor contributing to becoming an abuser...was the lack of understanding and knowledge of the aging process, and unrealistic expectations of the capabilities of elderly persons" (Chen et al, 1981). Douglass and Hickey (1981) report that one-fifth of the professionals they contacted noted that abusive families lack the "education or knowledge for understanding and responding to the needs of their older members."

7. Elder feels unwanted

As is often the case, an elderly person may be forced to rely on a relative to take them in. Due to an increased impairment of mobility or other physical deterioration, they can no longer care for themselves. In some cases the family may feel as though they have no choice and take the elder in out of feelings of familial obligation. In this new setting, the elderly may detect increasing family tensions due to their new position in the home. Block & Sinnott (1979) note that at times, the elder may attempt to resolve this tension by trying to prove their usefulness to the other members of the family. This may include taking on chores that are far beyond their strength and ability, resulting in abuse or neglect.

In a study of professionals conducted by Douglass et al. (1981), one of the problems reported was that often family members were too busy or pre-occupied to pay any attention to the elderly. As a result, isolation and the feeling of being unwanted often followed (Douglass et al, 1981).

8. Caretaker is misusing alcohol

Substance abuse by a caretaker of an aged individual is a topic that is mentioned in the literature on elder abuse, but there is little empirical evidence concerning the relationship between substance/alcohol abuse and elder abuse. In a literature review conducted by Chen et al (1982), there is an argument that substance abuse, which is a factor related to child abuse, may also be a factor that may lead to elder abuse.

Similarly, Rathbone-McCuan (1980) in examining intra-family violence, hypothesized that "abusive behavior associated with the consumption of intoxicants" was one of the factors that may have some connection to abuse of an elder. In this same study, it is noted

that in 4 of the 9 cases cited, there was some sort of excessive alcohol consumption by the abusive caretaker. Based on an analysis of those case studies, Rathbone-McCuan concluded that any major conclusion is questionable when based on such a small sample, it is confirmed by Wolf et al. (1982) who found that 40 percent of the abusers were having problems either with alcohol or drugs.

9. Caretaker tries to get elder to act against his/her best interest

Often a caretaker feels as though the elderly person whom they are caring for is out of control, hard to handle, etc. In an attempt to gain control over this situation, Block & Sinnott (1979) noted that the caretaker may give the elder large doses of sleeping pills or alcohol so that he/she will become more manageable. Block & Sinnott (1979) also note that elderly may, at times, be tied to a bed or chair in order to allow the caretaker to carry on with other activities.

10. Elder as a source of stress.

Several studies on domestic violence note that stress is often a strong predictor of abuse. Sengstock and Liang (1982) found that "domestic abuse is found to be worse in families with various stressful problems, all of them unrelated to the victim who is the focus of the abuse". Wolf et al (1982) notes that the elderly victim may be the source of stress due to their dependency on the caretaker.

LeRoy Schultz (1983) reviewed an article by Rathbone-McCuan (1982) which reported that in 65 percent of the cases of elder abuse, the victim was viewed as a source of stress to the abuser. Of all of the indicators of risk, the elderly as a source of stress appears to be the one most substantiated by previous research.

The research literature on elder abuse does not address six of the indicators listed on the Hwalek-Sengstock Elder Abuse Screening Protocol. However, preliminary data from the Illinois projects support the existence of these characteristics among elderly clients suspected to be victims of abuse and neglect.

Over the past several months, the research team has had the opportunity to collect additional information on the screening protocol in conjunction with an evaluation study of the four Illinois Department on Aging elder abuse demonstration projects. The screening protocol was completed by the social workers in the projects as part of a larger system of information being collected to help the state determine the need and cost of such programs.

Over a five month period, 63 of the 96 elderly referred to the projects were screened using the Hwalek-Sengstock Elder Abuse Screening Protocol. Scores on this index were not used to determine who would receive services, as the validity of the index has not yet been established. However, since these individuals were referred to the programs because of suspected abuse or neglect, it was hypothesized that for most of the sample, the items on the protocol should be present. Table Two provides the frequency distributions

for the items on an analysis of these 63 cases. The following risk indicators, then, are somewhat supported by this data:

Elder appears afraid of caretaker. Failure to report elder abuse may be based on fear. Elderly may be afraid that the abuser may retaliate if they learned of reports made to social service agencies. Thus, knowing that an elderly person is afraid of his/her caretaker may be a cue that elder abuse could be occurring. In the data from the Illinois Department on Aging, 56 percent of the elderly indicated that they were afraid of their caretakers.

Elder is Depressed. Among the elderly clients referred to the demonstration projects, 55.6 percent were determined by the social workers to be depressed.

No Illness related cause of symptoms. This indicator was assessed as present in 41 percent of the clients seen in the Illinois elder abuse projects. With 16 percent of the cases missing data on this indicator, about one-half of the elderly for whom this indicator was assessed were determined not to have an illness related cause of their symptoms. This indicator most likely refers to the presence of physical abuse. Since physical abuse was not the most common type of abuse seen at the projects, the presence of this indicator in as many as 40 percent of the cases supports it usefulness on the screening protocol.

Caretaker is a liar. This indicator is very difficult to assess, particularly when contact with the alleged abuser is often not possible. As would be expected, this indicator had a high percent of missing data. However, among those clients on which data was present, 46 percent indicated that the caretaker was a liar, compared with 38 percent who indicated that the caretaker was not a liar.

Elder's personal needs are not being met. Among the respondents in the Illinois study, 79 percent were not having their needs met by others. Only about one-fifth of the elderly indicated that their needs were sufficiently met. Thus, it appears that this indicator may be an important item for assessing risk of abuse.

Someone Threatened to Hurt the elder. This indicator was present in over one-third of the clients in the demonstration project. Given the fact that about one-third of the elderly were suspected to be victims of physical abuse, this indicator may prove to be important in predicting the presence of this type of abuse.

While these data are preliminary, they seem to support the content validity of the screening tool.

Criterion Related Validity

The second approach to test validation is criterion-related validity. Criterion-related validity is the degree to which scores on an index correspond to some other criterion known to demonstrate elder abuse. There are two types of criterion-related validity.

Predictive validity is the extent to which scores on an index correlate with future abuse. Concurrent validity is the extent to which scores on the index correlate with abuse and neglect currently existing. Both types of criterion-related validity are measured by the "validity coefficient," which is the correlation between scores on the index and the presence/absence of elder abuse or neglect at the time it is being measured (ie. the criterion) (Allen & Yen, 1979).

This process of examining criterion-related validity is time consuming, particularly in the area of elder abuse when access to large numbers of victims is difficult. However, the process of criterion-related validation has been initiated for the screening protocol.

Among the data being collected in the Illinois Elder Abuse Demonstration Projects is the service provides' indications of whether elder abuse was substantiated as a result of their investigations. Three categories of substantiation were provided: elder abuse was substantiated, elder abuse was suspected although conclusive evidence was not present and elder abuse was not substantiated. While using service providers' perceptions of substantiated abuse presents a problem of validating the criterion variable, this type of problem in criterion validation studies is not uncommon in the testing literature (cf. Mitchell, 1985). Unfortunately, sufficient data is not yet available from the Illinois study to examine the criterion-related validity of the protocol.

Construct Validity

There are two typesof construct validity. Convergent validity refers to the ability of the index to correlate, in the hypothesized direction, with measures of other variables hypothesized in the literature to be related. Divergent validity of a test is determined by showing that scores on the test do not correlate highly with scores on measures hypothesized in the literature not to be related.

An assessment of the construct validity of the Hwalek-Sengstock Elder Abuse Screening Protocol would be to show that high scores on the protocol correlated with such variables as alcoholism and mental impairment of the abuser. These variables have been shown in previous research to be related to the risk of abuse (Wolf et al. 1985). Alternatively, scores on the index should not be highly correlated with marital status or race, as these variables have not been substantially related to risk of abuse in past research. The need for construct validation of the protocol is apparent, and this is a direction of future research on this tool.

Issues of Reliability

Reliability of an index is an estimate of the extent to which the measure is free of random measurement error. A reliable screening protocol is one which consistently assesses an abusive situation as abusive. If the protocol classified an individual as "likely to be abused" one day, and "not likely to be abused" the

next, it would not be reliable, unless a significant change occurred in the condition of the individual between testing sessions. Another example of an unreliable protocol is one in which one social worker using the scale rated an individual as "likely to be abused," while another social worker rating the same person with the same index classified the individual as "not likely to be abused." The reliability of an index, therefore, is the extent to which we can trust the obtained score as a true measure of the risk of abuse.

These two types of reliability mentioned in the aforementioned examples are referred to as test-retest reliability and interrater reliability. Both types of reliability are important to the development of any screening protocol. Establishing the reliability of the Hwalek Sengstock Elder Abuse Screening Protocol is another direction of future research.

Ease of Use in Social Service Settings

Regardless of the reliability ratings and validity of an instrument, it is not a good tool for assessing risk of abuse if it is too difficult for service providers to use with their elderly clients. The Hwalek-Sengstock tool has already undergone two transformations in an attempt to determine the best design for use in a variety of settings serving the elderly.

There are several important issues that should be considered when determining the usefulness of the index in an applied setting. According to Smith (1985), several steps should be followed when reviewing tests for use. Smith (1985) suggests that the first step in examining any index is to read the items. A useful test does not contain extraneous material nor do the items overlap with other measures being collected on the same client. The items should cover essential issues and should be as specific or general as is needed in the situation.

The next step in reviewing a test for use is to review the research literature. According to Smith (1985), the test should predict patterns of relationships that would be expected. Studies using the instrument should show meaningful patterns of data.

Smith (1985) suggests that the wording of the items should also be carefully reviewed. The language used on the instrument should match the verbal level of the clients on whom it will be used. The wordings of the items should neither be "too difficult nor talk down to" the client (Smith, 1985).

In order for tests to be improved, Smith (1985) recommends that test users give feedback to test developers. Only with feedback from those using tests can the appropriate changes be made to improve their quality and usefulness.

Problems of Questionnaire Design

While the content of the protocol appears to support past and

present research on elder abuse, developing a questionnaire that will objectively assess the presence of each indicator poses several problems. First, the tool should be short enough to provide a rapid assessment of elderly in a variety of settings. Second, our research has shown that often the caretakers of the elderly and/or alleged abusers are not available for questioning. Third, to obtain objective and standardized data from a variety of agencies, questions on the protocol must be read exactly as they are written. Fourth, the respondent who answers the questions must be consistent over the variety of individuals who may be involved in cases of elder abuse.

Over the past several months, the research team has been working on transforming the indicators into questionnaire items. Inspection of each indicator with specialists in both crisis intervention and questionnaire design resulted in the current design of the Hwalek-Sengstock Elder Abuse Screening Protocol. Although each indicator is best represented by a series of questions, the time to complete the instrument and other practical constraints resulted in the decision to represent each indicator by only one question. The questions were ordered from the least sensitive to the most sensitive. They were phrased to allow a dichotomous (yes/no) response; and were written to be asked directly to the elderly.

The effectiveness of the design of the instrument is one of the issues presently being assessed in the Illinois Department on Aging Elder Abuse Demonstration Projects. Clearly much more research on the instrument needs to be done before it can be reliably used as an assessment of the risk of present or future abuse.

Advantages of the Elder Abuse Screening Protocol

There are several advantages of this risk assessment tool over other tools for identifying elder abuse used in the past. This instrument was developed using both an abused and a control group. Using the control group in this project has allowed the investigators to study indicators beyond the traditional demographic questions used on most risk assessment tools. This screening protocol, therefore, looks for more psychological and behavioral indicators of the risk of elder abuse and neglect.

Besides extending beyond the traditional demographic risk factors, the Hwalek-Sengstock Protocol uses indicators that have value in prescribing preventative or ameliorative programs for helping to prevent or resolve abuse. The presence of certain indicators can suggest a variety of strategies that can be used by service providers. For example, inappropriate awareness of the elder's conditions can be resolved by educational programming on caregiving for dependent elderly. Substance abuse can be alleviated by treatment programming. Financial stress may be alleviated through job placement services, or retraining programs. These indicators, therefore, offer more information and present potential avenues of alleviating the problem than do traditional demographic risk indicators. They may also be used to indicate prevention programming that could be effective for the elderly themselves.

particular importance is the use of this tool outside of the Adult Protective Service networks. If the protocol is to be accurate in estimating the incidence of elder abuse, it must be validated in a representative sample of community elderly. Cutoff scores for determining high vs. low risk of abuse must be determined by norming the measure on a large and varied population of the elderly. In spite of the infancy of the research on this tool, its development to date represents a major step toward assessing the probability of abuse and neglect of the elderly.

The authors are not yet satisfied with the amount of data on this index. Readers should be cautioned that more analyses are needed before the protocol can be recommended as a valid screening instrument. We are requesting that data collected on this tool be shared with the authors and the research community in general, so that validation of this instrument can be facilitated.

TABLE ONE

HWALEK-SENGSTOCK ELDER ABUSE SCREENING PROTOCOL

I HAVE A FEW QUESTIONS THAT WE'RE ASKING EVERYONE OVER THE AGE OF 60. SOME OF THESE QUESTIONS MAY NOT SEEM TO APPLY TO YOU, BUT WE NEED THIS INFORMATION TO SEE IF WE NEED MORE SERVICES FOR OLDER PEOPLE IN THIS STATE.

| | | |
|---|---|---|
| 1. Do you have anyone who spends time with you taking you shopping or to the doctor? | [ ]NO | [ ]YES |
| 2. Are you helping support someone? | [ ]NO | [ ]YES |
| 3. Do you have enough money to pay your bills on time? | [ ]NO | [ ]YES |
| 4. Are you sad or lonely often? | [ ]NO | [ ]YES |
| 5. Who makes decisions about your life - like how you should live or where you should live? | [ ]ELDER | [ ]OTHER |
| 6. Do you feel very uncomfortable with anyone in your family? | [ ]NO | [ ]YES |
| 7. Can you take your own medication and get around by yourself? | [ ]NO | [ ]YES |
| 8. Do you feel that nobody wants you around? | [ ]NO | [ ]YES |
| 9. Does anyone in your family drink a lot? | [ ]NO | [ ]YES |
| 10. Does someone in your family make you stay in bed or tell you you're sick when you know you're not? | [ ]NO | [ ]YES |
| 11. Has anyone forced you to do things you didn't want to do? | [ ]NO | [ ]YES |
| 12. Has anyone taken things that belong to you without your OK? | [ ]NO | [ ]YES |
| 13. Do you trust most of the people in your family? | [ ]NO | [ ]YES |
| 14. Does anyone ever tell you that you give them too much trouble? | [ ]NO | [ ]YES |
| 15. Do you have enough privacy at home? | [ ]NO | [ ]YES |
| 16. Has anyone close to you tried to hurt you or harm you recently? | [ ]NO | [ ]YES |

Hwalek-Sengstock (10-85)

Data from March to July, 1985

TABLE TWO
RISK ASSESSMENT DATA

| VARIABLE | ROCKFORD (N=9) | KANKAKEE (N=21) | CARBONDALE (N=19) | CHICAGO (N=14) | TOTALS FREQ | (N=63) PCTS |
|---|---|---|---|---|---|---|
| PERSONAL NEEDS MET BY OTHERS: | | | | | | |
| YES | 1 | 3 | 8 | 0 | 12 | 19.0% |
| NO | 8 | 18 | 11 | 13 | 50 | 79.4% |
| MISSING DATA | 0 | 0 | 0 | 1 | 1 | 1.6% |
| CARETAKER DEPENDENT ON ELDER: | | | | | | |
| YES | 5 | 10 | 7 | 11 | 33 | 52.4% |
| NO | 3 | 8 | 10 | 2 | 23 | 36.5% |
| MISSING DATA | 1 | 3 | 2 | 1 | 7 | 11.1% |
| FINANCIAL STRESS IN FAMILY: | | | | | | |
| YES | 8 | 10 | 5 | 11 | 34 | 54.0% |
| NO | 1 | 8 | 12 | 1 | 22 | 34.9% |
| MISSING DATA | 0 | 3 | 2 | 2 | 7 | 11.1% |
| ELDER IS DEPRESSED: | | | | | | |
| YES | 8 | 10 | 9 | 8 | 35 | 55.6% |
| NO | 1 | 7 | 7 | 2 | 17 | 27.0% |
| MISSING DATA | 0 | 4 | 3 | 4 | 11 | 17.5% |
| ELDER NOT SHARING IN DECISIONS: | | | | | | |
| YES | 8 | 13 | 12 | 11 | 44 | 69.8% |
| NO | 1 | 5 | 4 | 0 | 10 | 15.9% |
| MISSING DATA | 0 | 3 | 3 | 3 | 9 | 14.3% |
| MARITAL OR FAMILY DISCORD: | | | | | | |
| YES | 7 | 11 | 12 | 10 | 40 | 63.5% |
| NO | 2 | 8 | 5 | 1 | 16 | 25.4% |
| MISSING DATA | 0 | 2 | 2 | 3 | 7 | 11.1% |
| CARETAKER UNAWARE OF ELDER'S MEDICAL NEEDS: | | | | | | |
| YES | 8 | 16 | 16 | 12 | 52 | 82.5% |
| NO | 1 | 2 | 1 | 1 | 5 | 7.9% |
| MISSING DATA | 0 | 3 | 2 | 1 | 6 | 9.5% |
| ELDER IS UNWANTED: | | | | | | |
| YES | 6 | 11 | 12 | 12 | 41 | 65.1% |
| NO | 3 | 7 | 4 | 0 | 14 | 22.2% |
| MISSING DATA | 0 | 3 | 3 | 2 | 8 | 12.7% |
| ALCOHOL ABUSE IN FAMILY: | | | | | | |
| YES | 3 | 7 | 2 | 8 | 20 | 31.7% |
| NO | 4 | 11 | 14 | 4 | 33 | 52.4% |
| MISSING DATA | 2 | 3 | 3 | 2 | 10 | 15.9% |
| NO ILLNESS RELATED CAUSE OF SYMPTOMS: | | | | | | |
| YES | 7 | 7 | 4 | 8 | 26 | 41.3% |
| NO | 1 | 10 | 12 | 4 | 27 | 42.9% |
| MISSING DATA | 1 | 4 | 3 | 2 | 10 | 15.9% |
| TRIED TO GET ELDER TO ACT AGAINST OWN WILL: | | | | | | |
| YES | 6 | 7 | 3 | 8 | 24 | 38.1% |
| NO | 2 | 9 | 13 | 3 | 27 | 42.9% |
| MISSING DATA | 1 | 5 | 3 | 3 | 12 | 19.0% |
| SOMEONE TOOK PROPERTY FROM ELDER: | | | | | | |
| YES | 6 | 14 | 10 | 12 | 42 | 66.7% |
| NO | 1 | 4 | 6 | 1 | 12 | 19.0% |
| MISSING DATA | 2 | 3 | 3 | 1 | 9 | 14.3% |
| CARETAKER IS A LIAR: | | | | | | |
| YES | 5 | 7 | 8 | 9 | 29 | 46.0% |
| NO | 3 | 10 | 9 | 2 | 24 | 38.1% |
| MISSING DATA | 1 | 4 | 2 | 3 | 10 | 15.9% |
| ELDER IS A SOURCE OF STRESS: SYMPTOMS: | | | | | | |
| YES | 8 | 14 | 13 | 11 | 46 | 73.0% |
| NO | 0 | 4 | 4 | 2 | 10 | 15.9% |
| MISSING DATA | 1 | 3 | 2 | 1 | 7 | 11.1% |
| ELDER IS AFRAID OF CARETAKER: | | | | | | |
| YES | 7 | 9 | 10 | 9 | 35 | 55.6% |
| NO | 1 | 9 | 7 | 3 | 20 | 31.7% |
| MISSING DATA | 1 | 3 | 2 | 2 | 8 | 12.7% |
| SOMEONE THREATENED TO HURT ELDER: | | | | | | |
| YES | 5 | 6 | 6 | 6 | 23 | 36.5% |
| NO | 3 | 12 | 10 | 6 | 31 | 49.2% |
| MISSING DATA | 1 | 3 | 3 | 2 | 9 | 14.3% |



BEST COPY AVAILABLE

## REFERENCES


Allen, M.J., and Yen, W.M.. Introduction to Measurement Theory. Monterey, California: Brooks

Block, Marilyn R., and Jan D. Sinnott, 1979. The Battered Elder Syndrome:An Exploratory Study. College Park, MD: Center on Aging

Campbell, D.T., and D.W. Fiske, 1959. "Convergent and discriminant validation by the multitrait-multimethod matrix." Psychol: Bull., 56, 81-105.

Carmine, E.G. and Richard Zeller. Reliability and Validity Assessment. Beverly Hills: Sage, 1979.

Chen, Pei N., S.L. Bell, D.L. Dolinsky, J. Doyle, and M. Dunn, 1981. "Elderly Abuse in Domestic Settings." Journal of Gerontological Social Work 4 (1): 3-18.

Davidson, Janice, 1979. "Elder Abuse" in Block and Sinnott (Eds.) The Battered Elder Syndrome: An Exploratory Study. College Park, MD: Center on Aging.

Douglass, Richard L., Thomas Hickey, and Catherine Noel, 1980. A Study of Maltreatment of the Elderly and Other Vulnerable Adults. Ann Arbor, MI: Institute of Gerontology, University of Michigan.

Gelles, Richard J. The Violent Home. Beverly Hills, California: Sage, 1974.

Hwalek, Melanie, Mary C. Sengstock, and Renee Lawrence, 1984. "Assessing the Probability of Abuse of the Elderly" Paper presented at the 37th Annual Meeting of the Gerontological Society of America, San Antonio, 1984.

Lau, Elizabeth, and Jordon Kosberg, 1979. "Abuse of the Elderly by Informal Care Providers." Aging, Sept./Oct.: 10-15.

Rathbone-McCuan, E. "Elderly Victims of Family Violence and Neglect" Social Casework, 296-304, 1980.

Salend, Elyse, Rosalie A. Kane, Maureen Satz, and Jon Pynoos, 1984. "Elder Abuse Reporting: Limitations of Statutes." The Gerontologist 24: 61-69

Sengstock, Mary C.m and Jersey Liang, 1982. Identifying and Characterizing Elder Abuse. Detroit: Institute of Gerontology, Wayne State University.

Smith, Patricia. "Global Measures: Do We Need Them?" Paper presented at the 93rd Annual Convention of The American Psychological Association, Los Angeles, 1985.

Wolf, R.S., Stugnell, C.P., Godkin, M.A., "Preliminary Findings From Three Model Projects on Elderly Abuse." Massachusetts: University Center on Aging, 1982.